House Bill 307

By: Representatives Cole of the 125th and Ramsey of the 72nd

A BILL TO BE ENTITLED

AN ACT

To amend Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to the care and protection of indigent and elderly patients, so as to provide for a fee to be imposed on hospitals to be used to obtain federal financial participation for medical assistance payments under Medicaid; to provide for definitions; to establish a segregated account within the Indigent Care Trust Fund for the deposit of provider fees; to provide for a method for calculating and collecting the provider fee; to authorize the Department of Community Health to inspect hospital records for purposes of auditing provider fees; to provide for penalties for failure to pay a provider fee; to authorize the department to withhold Medicaid payments equal to amounts owed as a provider fee and penalty; to provide for the collection of fees by civil action and tax liens; to provide for the appropriation of funds in the segregated account for medical assistance payments; to provide for application of the "Georgia Medical Assistance Act of 1977"; to revise definitions relating to quality assessment fees on care management organizations; to revise language relating to the maximum aggregate quality assessment fees which may be imposed; to provide for related matters; to provide for an effective date; to repeal conflicting laws; and for other purposes.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF GEORGIA:

SECTION 1.

Chapter 8 of Title 31 of the Official Code of Georgia Annotated, relating to the care and protection of indigent and elderly patients, is amended by adding a new article to read as follows:

"ARTICLE 6C

31-8-179.

This article is enacted pursuant to the authority of Article III, Section IX, Paragraph VI(i) of the Constitution.

31-8-179.1.

As used in this article, the term:

(1) 'Department' means the Department of Community Health.

(2) 'Hospital' means an institution licensed pursuant to Chapter 7 of this title which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, and other specialty hospitals but shall not include psychiatric hospitals as defined in paragraph (7) of Code Section 37-3-1 or any state owned or state operated hospitals.

(3) 'Net patient revenue' means the total gross patient revenue of a hospital less contractual adjustments; charity care; bad debt; Hill-Burton commitments; and indigent care as defined by and calculated in accordance with department guidelines.

(4) 'Provider fee' means the fee imposed pursuant to this article for the privilege of operating a hospital.

(5) 'Segregated account' means an account for the dedication and deposit of provider fees which is established within the Indigent Care Trust Fund created pursuant to Code Section 31-8-152.

(6) 'Trust fund' means the Indigent Care Trust Fund created pursuant to Code Section 31-8-152.

31-8-179.2.

There is established within the trust fund a segregated account for revenues raised through the imposition of the provider fee. All revenues raised through provider fees shall be credited to the segregated account within the trust fund, except as otherwise provided for in Code Section 31-8-179.4, and shall be invested in the same manner as authorized for investing other moneys in the state treasury. Contributions and transfers to the trust fund pursuant to Code Sections 31-8-153 and 31-8-153.1 shall not be deposited into the segregated account.

31-8-179.3.

(a) Each hospital shall be assessed a provider fee, assessed uniformly upon all hospitals, in the amount of the lesser of 1.6 percent of the net patient revenue of the hospital or the maximum amount that may be assessed pursuant to the percentage limitation of the first prong of the test for an indirect guarantee set out in 42 C.F.R. Section 433.68(f)(3)(i).

(b) The provider fee shall be paid quarterly by each hospital to the department. The assessment shall be based on the most recent completed annual financial report prepared by the department. Payment of the provider fee shall be due no later than the thirtieth day following the end of each calendar quarter; the first payment shall be due on September 1, 2009, and the final payment of the first year shall be due no later than May 31, 2010.

31-8-179.4.

(a) The department shall collect the provider fees imposed pursuant to Code Section 31-8-179.3. No less than 90 percent of revenues raised pursuant to this article shall be deposited into the segregated account. Such funds shall be dedicated and used for the sole purpose of obtaining federal financial participation for medical assistance payments to providers on behalf of Medicaid recipients pursuant to Article 7 of Chapter 4 of Title 49. Up to 10 percent of revenues raised pursuant to this article may be deposited into the general treasury with the intent that such funds be used for trauma care.

(b) The department shall prepare and distribute a form upon which each hospital shall submit information to comply with this article.

(c) Each hospital shall keep and preserve for a period of three years such books and records as may be necessary to determine the amount for which it is liable under this article. The department shall have the authority to inspect and copy the records of a hospital for purposes of auditing the calculation of the provider fee. All information obtained by the department pursuant to this article shall be confidential and shall not constitute a public record.

(d) In the event the department determines that a hospital has underpaid or overpaid the provider fee, the department shall notify the hospital of the balance of the provider fee or refund that is due. Such payment or refund shall be due within 30 days of the department's notice.

(e) Any hospital that fails to pay the provider fee pursuant to this article within the time required by this article shall pay, in addition to the outstanding provider fee, a 6 percent penalty for each month or fraction thereof that the payment is overdue. If a provider fee has not been received by the department by the last day of the month, the department shall withhold an amount equal to the provider fee and penalty owed from any medical assistance payment due such hospital under the Medicaid program. The provider fee levied by this article shall constitute a debt due the state and may be collected by civil action and the filing of tax liens in addition to such methods provided for in this article. Any penalty that accrues pursuant to this subsection shall be credited to the segregated account.

(f) The Governor may suspend the collection of the provider fees, or any part thereof, imposed pursuant to this article due the state until no later than the meeting of the next

General Assembly, but the Governor shall not otherwise interfere with the collection of such fees.

31-8-179.5.

(a) Notwithstanding any other provision of this chapter, the General Assembly is authorized to appropriate as state funds to the department for use in any fiscal year all revenues dedicated and deposited into the segregated account. Such appropriations shall be made for the sole purpose of obtaining federal financial participation for medical assistance payments to providers on behalf of Medicaid recipients pursuant to Article 7 of Chapter 4 of Title 49. Any appropriation from the segregated account for any purpose other than such medical assistance payments shall be void.

(b) Revenues appropriated to the department pursuant to this Code section shall be used to match federal funds that are available for the purpose for which such trust funds have been appropriated.

(c) Appropriations from the segregated account to the department shall not lapse to the general fund at the end of the fiscal year.

31-8-179.6.

The department shall report annually to the General Assembly on its use of revenues deposited into the segregated account and appropriated to the department pursuant to this article.

31-8-179.7.

Except where inconsistent with this article, the provisions of Article 7 of Chapter 4 of Title 49, the 'Georgia Medical Assistance Act of 1977,' shall apply to the department in carrying out the purposes of this article."

SECTION 2.

Said chapter is further amended in Code Section 31-8-171, relating to definitions relative to quality assessment fees on care management organizations, by revising paragraph (1) as follows:

"(1) 'Care management organization' means an entity granted a certificate of authority under Chapter 21 of Title 33 ~~of the Official Code of Georgia Annotated~~, an entity offering an accident and sickness policy as defined in Code Section 33-29-1, and an entity operating as a preferred provider pursuant to Chapter 30 of Title 33 and which meets the definition found in 42 U.S.C. Sec. 1396b(w)(7)(A)(viii) as it ~~now exists or as it may be amended in the future~~ exists on July 1, 2009; provided however, that the term

shall not include a health benefit policy as defined in paragraph (1.1) of Code Section 33-1-2.″

SECTION 3.

Said chapter is further amended in Code Section 31-8-173, relating to the assessment, calculation, and payment of quality assessment fees on care management organizations, by revising subsection (a) as follows:

″(a) Each care management organization shall be assessed a quality assessment fee, in an amount to be determined by the department based on anticipated revenue estimates included in the state budget report, with respect to its gross direct premiums. The quality assessment fee shall be assessed uniformly upon all care management organizations. The aggregate quality assessment fees imposed under this article shall not exceed the lesser of 1.6 percent of the gross direct premium of the care management organization or the maximum amount that may be assessed pursuant to 42 C.F.R. Section 433.68(f)(3)(I). The Governor may suspend the collection of the quality assessment fees, or any part thereof, imposed pursuant to this article due the state until no later than the meeting of the next General Assembly, but the Governor shall not otherwise interfere with the collection of such fees.″

SECTION 4.

This Act shall become effective upon its approval by the Governor or upon its becoming law without such approval.

SECTION 5.

All laws and parts of laws in conflict with this Act are repealed.